IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

AARON ROME,	§	
	§	
Plaintiff,	§	
v.	§	
	§	
DANIEL M. LIBBY, HCC LIFE INSURANCE COMPANY, HCC SPECIALTY UNDERWRITERS, INC., THE NATIONAL HOCKEY LEAGUE, THE NHL PLAYERS' HEALTH AND BENEFITS FUND, THE BOARD OF TRUSTEES, NATIONAL HOCKEY LEAGUE PLAYERS' HEALTH FUND A/K/A THE BOARD OF TRUSTEES OF THE NHL PLAYERS' HEALTH AND BENEFITS FUND, and CRAIG HARNETT,	§	C.A. No. 3:16-CV-02480-N
	§	
Defendants.	§	
	§	

DEFENDANTS HCC LIFE INSURANCE COMPANY, HCC SPECIALTY UNDERWRITERS, INC., THE NHL PLAYERS' HEALTH AND BENEFITS FUND, AND DANIEL M. LIBBY'S MOTION TO DISMISS OR, IN THE ALTERNATIVE, MOTION FOR SUMMARY JUDGMENT OR PARTIAL SUMMARY JUDGMENT AND BRIEF IN SUPPORT

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DEFENDANTS HCC LIFE INSURANCE COMPANY, HCC SPECIALTY UNDERWRITERS, INC., THE NHL PLAYERS' HEALTH AND BENEFITS FUND, AND DANIEL M. LIBBY'S MOTION TO DISMISS OR, IN THE ALTERNATIVE, MOTION FOR SUMMARY JUDGMENT OR PARTIAL SUMMARY JUDGMENT AND BRIEF IN SUPPORT

Despite artfully-pleaded state law claims, Plaintiff's Complaint is fundamentally an unpled claim for disability benefits under an ERISA plan. Because ERISA preempts state law claims that seek to alter ERISA's remedial provisions, Defendants HCC Life Insurance Company, HCC Specialty Underwriters, Inc., and The NHL Players' Health and Benefits Fund and Daniel M. Libby (collectively, "Defendants") move for dismissal with prejudice of all state law claims pursuant to Federal Rule of Civil Procedure 12(b)(6) or, in the alternative, for

summary judgment pursuant to Federal Rule of Civil Procedure Rule 56.[1] In addition, Plaintiff should not be allowed to proceed with any ERISA claims because he has not exhausted his administrative remedies under the insurance plan.

Even if Plaintiff could plead a claim for benefits under ERISA § 502(a)(1)(B) (29 U.S.C. § 1132(a)(1)(B)), his claim could only proceed against the plan defendant, HCC Life Insurance Company. No other defendant is a proper party for a claim for benefits. Finally, personal jurisdiction does not exist over Defendant Libby, and Libby was not properly served. This creates independent bases for dismissal of the claims against Libby. *See* Fed. R. Civ. P. 12(b)(2), (b)(5).

INTRODUCTION

HCC Life Insurance Company ("Insurer") issued a disability policy ("Policy") to Defendant National Hockey League ("NHL") for the benefit of active NHL hockey players. The Policy is established and maintained pursuant to a Collective Bargaining Agreement ("CBA") between the NHL and the National Hockey League Players' Association ("NHLPA"), and it constitutes an employee welfare benefit plan. As such, the Policy/Plan is subject to ERISA.[2]

Plaintiff Aaron Rome, a former NHL player, sought benefits under the Policy, and the Insurer later denied his claim pursuant to a claims review letter dated February 5, 2016. In that letter, Rome and his counsel were advised they had to request an administrative appeal of the original claim decision, and then complete that appeal process, ***before*** bringing a civil action. Plaintiff did request an appeal, but days later, before submitting any additional information, he filed this lawsuit. As a matter of law, by pursuing legal action before completing the appeal

[1] The other defendants in this action have not been served; thus, they are not moving for relief herein. However, the Court's ruling on dismissal or summary judgment should likewise dismiss claims against these other defendants for the same reasons set forth herein.

[2] Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001-1461 ("ERISA").

process, Plaintiff inexcusably failed to exhaust his administrative remedies under the ERISA-governed Policy, and as a result, this lawsuit must be dismissed with prejudice. *See, inter alia, McGowin v. ManPower Int'l, Inc.*, 363 F.3d 556, 559 (5th Cir. 2004); *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 33 (5th Cir. 1993).

Even ignoring ERISA preemption and his failure to exhaust administrative remedies (which completely bar Plaintiff's claims), Plaintiff has sued numerous improper parties. Under ERISA, Plaintiff's potential claim for benefits may only be pursued against the Insurer (HCC Life). The other parties are not responsible for payment of disability benefits and may not be sued under ERISA Section 502(a)(1)(B). *See, e.g., Armando v. AT&T Mobility*, 487 F. App'x 877, 878-79 (5th Cir. 2012).

In addition, because Defendant Libby is a Massachusetts resident with no relevant Texas contacts, personal jurisdiction regarding the alleged state law claims does not exist, and even if such contacts existed, Libby was not properly served with the summons and complaint in this lawsuit.

STATEMENT OF FACTS

Defendants

1. Defendant HCC Life Insurance Company ("HCC Life" or "Insurer") is the insurance company that issued the Policy at issue in this lawsuit. (Appendix (hereinafter "App") App. 1 (Ex. 1 - Decl. of Cooney) at ¶ 5, Exhibit A, App. 6 (The Policy) at App. 11)

2. Defendant HCC Specialty Underwriters, Inc. is the claim-adjusting agent for HCC Life. (App. 1 (Ex. 1 - Decl. of Cooney) at ¶ 3)

3. At all times relevant, Defendant Daniel Libby was a claims specialist employed by HCC Specialty Underwriters, Inc. (agent for the Insurer) with respect to Plaintiff's claim. (App. 382 (Ex. 3 - Decl. of Libby) at ¶ 1)

4. Unserved Defendant The National Hockey League is an unincorporated ice hockey league composed of 30 member clubs located throughout the United States and Canada. (App. 67 (Ex. 2 - Decl. of Harnett), App. 68 at ¶ 3)

5. Defendant The NHL Players' Health and Benefits Fund (the "Fund") is a trust fund jointly established by the NHL and the NHLPA to provide benefits to NHL players pursuant to the CBA between the NHL and the NHLPA. (App. 67 (Ex. 2 - Decl. of Harnett), App. 68 at ¶ 4)

6. Unserved Defendant Board of Trustees, National Hockey League Players' Health Fund a/k/a The Board Of Trustees Of The NHL Players' Health and Benefits Fund (the "Board") is the plan sponsor and plan administrator of the Fund; the composition of the Board is based on the negotiated CBA and includes representatives selected by the NHL and the NHLPA. (App. 67 (Ex. 2 - Decl. of Harnett), App. 68 at ¶ 5)

7. Unserved Defendant Craig Harnett is a member of the Board. (App. 67 (Ex. 2 - Decl. of Harnett), App. 68 at ¶ 6)

The Policy

8. Insurer HCC Life issued Policy Number HL03PCT10050/ Certificate No. 152006 (the "Policy") to the "National Hockey League and Its Member Clubs" with effective dates of January 13, 2013 through January 13, 2016. (App. 1 (Decl. of Cooney) at ¶ 5, Exhibit A, App. 6 (The Policy) at App. 8)[3]

9. The Policy is an ERISA Benefit Plan (the "Plan") established and maintained by the NHL and NHLPA to provide disability benefit coverage to active NHL players. In addition to disability benefits, the Fund also provides other benefits including medical coverage, dental coverage, life insurance and accidental death coverage, and spousal life and accidental death and

3 The "National Hockey League and Its Member Clubs" is the legal name for the NHL.

dismemberment coverage. (App. 67 (Ex. 2 – Decl. of Harnett), App. 68 at ¶ 7; also see App. 189-191)

10. Subject to its terms, conditions, and exclusions, the Policy provides benefits in the event of disability to the "Insureds". (App. 1 (Decl. of Cooney), App. 2 at ¶ 5, Exhibit A, App. 6 (The Policy) at App. 7) The Policy's Schedule defines five categories of "Insureds," and each category includes the requirement that the hockey player be considered an "active" (non-retired) player in the National Hockey League, a concept defined separately in the CBA. (App. 1 (Decl. of Cooney), App. 2 at ¶ 5, Exhibit A, App. 6 (The Policy) at App. 8)

11. The NHL Clubs contribute to the Fund for the costs of the benefits provided by the Fund, and the Fund is responsible to pay all premium payments due to the Insurer under the Policy. (App. 67 (Ex. 2 – Decl. of Harnett), App. 68 at ¶ 8)

12. The Board files a "Form 5500" with the Internal Revenue Service with respect to the Fund. Form 5500 is entitled "Annual Return/Report of Employee Benefit Plan" and contains instructions that "*This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).*" (App. 67 (Ex. 2 – Decl. of Harnett), App. 69 at ¶ 9; also see Exhibit A, App. 72 (Form 5500) at App. 73)

Plaintiff's Claim

13. On or about December 19, 2014, Plaintiff submitted a disability claim form to the Insurer.

14. On February 5, 2016, the Insurer issued its claims review letter to Plaintiff and his attorney, advising Plaintiff that no benefits were payable. (App. 1 (Decl. of Cooney), App. 2 at ¶ 7, Exhibit B, App. 41 (Feb. 5, 2016 letter) at App. 42-47)

15. The February 5, 2016 letter from the Insurer to Plaintiff explained the ERISA procedure for appealing the Insurer's decision as follows:

> Because the Certificate is part of an ERISA plan [Employee Retirement Income Security Act of 1974], you have the right to have HCC Life Insurance Company review and reconsider the denial of your claim. Additionally, you have the right to review all documents pertinent to your claim, at no charge. If you wish to have HCC Life Insurance Company review and reconsider the denial of your claim, please advise us in writing within one hundred and eighty (180) days that you desire such a review. At that time, please submit any additional information, issues or comments, in writing, which Rome believes are pertinent to your claim. The appeal will be resolved within forty-five (45) days, unless special circumstances exist which may result in an extension of an additional forty-five (45) days to render a decision on your appeal. If you receive an adverse determination on your claim after review, you then have the right to file a civil action under ERISA. If you do not request a review of the denial of your claim within one hundred eighty (180) days, the denial will be final and you may be barred from bringing a legal action based upon your failure to exhaust administrative remedies.
>
> (App. 1 (Decl. of Cooney), App. 2 at ¶ 7, Exhibit B, App. 41 (Feb. 5, 2016 letter) at App. 46-47)

16. After the February 5, 2016 letter was issued, significant correspondence was exchanged between the parties in which Plaintiff's counsel was provided additional information concerning the decision, the appeal process, and the ERISA-based nature of the plan. (App. 1 (Decl. of Cooney), App. 2-4 at ¶¶ 8-13, Exhibits C, B, D, E, F, G, & H, App. 48 - 66)

State Court Complaint

17. On August 3, 2016, six days after requesting an appeal of the original claim decision, Plaintiff filed this action in Dallas state court. In the Petition, Plaintiff alleges claims for relief for "V. Request for Declaratory Relief; VI. Breach of Conduct; IX. Conspiracy to Violate Sections 541.060 and 541.061 of the Texas Insurance Code; and X. Vicarious Liability." (*See* Complaint, pp. 8-12, at Dkt. # 1-2)

18. On August 26, 2016, HCC Life timely filed a Notice of Removal in the Northern District of Texas, contending the District Court had subject matter jurisdiction as the claim was

governed by ERISA and, alternatively, the District Court had diversity jurisdiction. (*See* Dkt. #1)

ARGUMENTS AND AUTHORITIES

II. LEGAL STANDARD FOR MOTION TO DISMISS OR, ALTERNATIVELY, FOR SUMMARY JUDGMENT

A complaint "must contain… a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). In order to survive a motion to dismiss, a plaintiff must articulate "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

The Fifth Circuit has affirmed that, as long as the documents are referred to in the plaintiff's complaint and central to the claim, the court may consider a document attached to a motion to dismiss without converting the motion into one for summary judgment. *Collins v. Morgan Stanley Dean Witter* 224 F.3d 496, 498-99 (5th Cir. 2000). On that legal basis, this Court can consider documents attached to this Motion without converting it to a motion for summary judgment. These documents include the Policy at issue and written communications between the Insurer and the Claimant during the claim investigation.

Alternatively, Rule 56(c) of the Federal Rules of Civil Procedure allows summary judgment when there is no genuine issue as to any material fact and the party moving for summary judgment is entitled to judgment as a matter of law. *See* Fed. R. Civ. P. 56(a); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986); *Melton v. Teachers Ins. & Annuity Ass'n of Am.*, 114 F.3d 557, 559 (5th Cir. 1997).

III. THE POLICY IS GOVERNED BY ERISA.

ERISA defines an "employee welfare benefit plan" as:

> any plan, fund or program which was … established or maintained by an employer or by an employee organization, or by both, to the extent that ***such plan, fund or program was established or is maintained for the purpose of providing for its participants*** or their beneficiaries, ***through the purchase of insurance*** or otherwise, (A) medical, surgical, or hospital care or benefits, or ***benefits in the event of*** sickness, accident, ***disability***, death or unemployment….

29 U.S.C. § 1002(1) (emphasis added).

To determine whether a particular plan qualifies as an ERISA employee welfare benefit plan, this Court must determine whether the Plan: (1) exists; (2) falls outside the Department of Labor's safe-harbor provision; and (3) satisfies the primary elements of an ERISA "employee benefit plan"—a plan established or maintained by an employer and/or employee organization for the benefit of employees. *See Martin v. Trend Pers. Servs.*, 2016 U.S. App. LEXIS 16146, at*4 (5th Cir. Aug. 31, 2016) (quoting *Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993)). Here, as a matter of law, the Policy is a part of an ERISA plan; indeed, this case involves a quintessential ERISA plan.

A. Existence of a Plan.

A formal document designated as "the Plan" is not required to show an ERISA plan exists. *See Mem'l Hosp. Sys. v. Northbrook Life Ins., Co*. 904 F.2d 236, 240-241 (5th Cir. 1990) (citing *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982)); *see also Davis v. Reliance Standard Life Ins. Co.*, No. 3-03-CV-2535-BD, 2004 U.S. Dist. Lexis 13595, at * 7-8 (N.D. Tex. July 19, 2004). Rather, the Fifth Circuit has held an ERISA plan exists if "a reasonable person could ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *Mem'l Hosp. Sys.*, 904 F.2d at 240 (quoting *Donovan*, 688 F.2d at 1373). That test is easily met here. The Policy provides for specified

disability benefits to active NHL players and provides a formula for calculating benefits. (App. 1 (Ex. 1 - Decl. of Cooney) at ¶ 5, Exhibit A, App. 6 (The Policy) at App. 9) Similarly, the NHL Clubs are ultimately responsible for paying the premiums pursuant to the terms of the CBA, and the Policy sets forth the relevant claims procedures. (App. 67 (Ex. 2 – Decl. of Harnett), App. 68 at ¶ 8; also see Policy, Exhibit A to Decl. of Cooney beginning at App. 7). Therefore, an ERISA Plan exists.

B. The Policy Does Not Fall Within ERISA's Safe Harbor Regulation.

The Safe Harbor regulation provides:

> [T]he terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which (1) [n]o contributions are made by an employer or employee organization; (2) [p]articipation in the program is completely voluntary for employees or members; (3) [t]he sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and (4) [t]he employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j).

Failure to satisfy any one of the Safe Harbor criteria means that a group-type insurance program will not be exempt from ERISA under this provision. *Mem'l Hosp. Sys.*, 904 F.2d at 241, n.6. Here, as a matter of law, three of the above four Safe Harbor criteria cannot be satisfied, meaning ERISA coverage exists.

1. The First Safe Harbor Criterion is not satisfied.

The first criterion—no contributions are made by an employer—cannot be satisfied because the NHL Clubs solely make contributions to the Fund for Policy premium payments. (App. 67 (Ex. 2 – Decl. of Harnett), App. 68 at ¶ 8)

2. The Second Safe Harbor Criterion is not satisfied.

The second criterion—participation in the program is voluntary—cannot be satisfied because the bargaining parties agreed to provide coverage to eligible active NHL players with no option to decline. (App. 67 (Ex. 2 – Decl. of Harnett), App. 68 at ¶ 7; also see Exhibit A to Decl. of Cooney at App. 7-40 (the Policy); also see Exhibit B to Decl. of Harnett, App. 189-284 (Benefits Guides and Relevant CBA provisions)

3. The Third Safe Harbor Criterion is not satisfied.

The third criterion—the employer and/or employee organization role is limited to collecting premiums and remitting them to the insurer—cannot be satisfied because the NHL and NHLPA not only selected the insurer, but they also negotiated the key terms of the Policy, including but not limited to eligibility criteria and coverage amounts. (App. 67 (Ex. 2 – Decl. of Harnett), App. 68 at ¶ 5)

Because Plaintiff cannot satisfy at least three of the Safe Harbor criteria, ***let alone all of them*** as would be required, the Safe Harbor exception does not apply and the plan is covered by ERISA.

C. Establishment and Maintenance of a Plan.

ERISA does not regulate the bare purchase of insurance. *Kerans v. Provident Life & Accident Ins. Co.,* 452 F. Supp. 2d 665, 674 (N.D. Tex. 2005). Rather, "[t]he employer must have some 'meaningful degree of participation… in the creation or administration of the plan.'" *Id.* (quoting *Hansen v. Cont'l Ins. Co.,* 940 F.2d 971, 978 (5th Cir. 1990)). Although the mere purchase of insurance is insufficient to prove an ERISA plan was established, "the purchase of a policy or multiple policies covering a class of employees offers ***substantial evidence*** that a plan, fund, or program has been established." *Mem'l Hosp. Sys.* 904 F.2d at 242 (emphasis added) (quoting *Donovan,* 688 F.2d at 1373). According to the Northern District of Texas, if an

employer purchases disability insurance as well as health insurance for its employees, "[t]his suggests that the disability policy was part of 'an overall design of employee benefits' constituting an ERISA plan." *Davis*, 2004 U.S. Dist. LEXIS 13595, *11 (quoting *Salameh v. Provident Life & Accident Ins. Co.*, 23 F. Supp. 2d 704, 710 (S.D. Tex. 1998)).

Here, in addition to disability insurance coverage, the NHL players are provided with medical coverage, dental coverage, life insurance and accidental death coverage, and spousal life and accidental death and dismemberment coverage. (App. 67 (Ex. 2 – Decl. of Harnett), App. 68 at ¶ 7; also see Exhibit B to Decl. of Harnett, App. 189-244 (Benefits Guides and relevant CBA provisions) Under *Davis*, this undeniably constitutes an ERISA plan.

Further, NHL and/or the NHLPA are not simply offering insurance for NHL players to purchase. To the contrary, insurance coverage—disability and otherwise—are established and maintained pursuant to a CBA that was negotiated between the NHL and the NHLPA. The bargaining parties selected the Insurer, determined various eligibility and coverage provisions, and created the funding mechanism for the employee benefits- the NHL and hockey clubs pay all costs, and the players pay nothing. (App. 67 (Ex. 2 – Decl. of Harnett), App. 68 at ¶¶ 4-8; also see Exhibit B to Decl. of Harnett, App. 189-284 (Benefits Guides and relevant CBA provisions) Accordingly, under *Memorial Hospital System* and other Fifth Circuit law, an ERISA Plan, thus, has been "established or maintained." *See also Kidder v. H & B Marine, Inc.*, 932 F.2d 347, 353 (5th Cir. 1991) (employer established and maintained a plan when it paid premiums on behalf of employees and intended to provide welfare benefit program); *Kerans*, 425 F. Supp. 2d at 674 (citing cases).

IV. STATE LAW CLAIMS ARE PREEMPTED AND THE EXCLUSIVE REMEDY IS 29 U.S.C. § 1132(a)(1)(B).

"It is clear that ERISA preempts a state law cause of action brought by an ERISA plan participant or beneficiary alleging improper processing of a claim for plan benefits." *Mem'l Hosp. Sys.*, 904 F.2d at 245 (citing *Pilot Life Ins. Co v. Dedeaux*, 481 U.S. 41, 88 (1987)); *see also McNeil v. Time Ins. Co.*, 205 F.3d 179, 191 (5th Cir. 2000) (ERISA preempts a state law claim "if that claim addresses an area of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan….").

In the present case, Plaintiff alleges various state law claims challenging the Insurer's denial of disability benefits under the Policy and seeks court-ordered payment of those benefits as well as other relief. (*See* Pl.'s Original Petition, at pp.8-12 & Prayer for Relief at Dkt. # 1-2) Because the underlying Policy/Plan is governed by ERISA, Plaintiff's state law claims are preempted as a matter of law.

Rather than Plaintiff's unfounded state law claims, the proper ERISA remedial provision is 29 U.S.C. §1132(a)(1)(B), which provides a participant with the ability to sue for "benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

V. PLAINTIFF'S CLAIMS ARE BARRED FOR FAILURE TO EXHAUST ADMINISTRATIVE REMEDIES.

A. The ERISA Exhaustion Doctrine.

It is well-settled in the Fifth Circuit that the "exhaustion doctrine" applies to suits for benefits under ERISA, 29 U.S.C. §1132(a)(1)(B). *See Moss v. Unum Grp.*, 638 F. App'x 347, 349 (5th Cir. 2016); *see also McGowin v. ManPower Int'l, Inc.*, 363 F.3d 556, 559 (5th Cir. 2004) (citing *Bourgeois v. Pension Plan for Employees of Santa Fe Int'l Corp.*, 215 F.3d 475, 479 (5th Cir. 2000)); *see also Galvan v. SBC Pension Benefit Plan* 204 F. App'x 335, 340 (5th

Cir. 2005) (quoting *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 33 (5th Cir. 1993) ("Our court fully endorse[s] the *prerequisite* of exhaustion of administrative remedies in the ERISA context.") Under the exhaustion doctrine, before a participant may bring suit for alleged wrongful denial of benefits under an employee welfare benefit plan, all available administrative remedies in the plan's claims process must be exhausted. *See Bourgeois*, 215 F.3d at 479. A participant's failure to exhaust available administrative remedies entitles the plan administrator/insurer to summary judgment. *McGowan v. New Orleans Emp'rs Int'l Longshoremen's Ass'n*, 538 F. App'x 495, 498-99 (5th Cir. 2013); *see also Coop. Benefit Adm'rs, Inc. v. Ogden*, 367 F.3d 323, 336 (5th Cir. 2004).

The exhaustion doctrine increases judicial efficiency because a claimant cannot know the final benefit claim decision until all administrative remedies have properly been pursued. An unnecessary lawsuit is avoided if the claim is determined, on review, to be payable. If, on the other hand, the claim is denied, the claimant can review the specific reasons for the denial and make an informed decision as to whether that denial should be challenged with a lawsuit. As stated by the Fifth Circuit, "[o]ne of the policies underlying the exhaustion requirement was Congress's desire that ERISA trustees, not federal courts, be responsible for their actions so that not every ERISA action becomes a federal case." *See Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 33 (5th Cir 1993) (citing *Denton v. First Nat'l Bank*, 765 F.2d 1295, 1300 (5th Cir. 1985)).

For the above reasons, courts routinely find lawsuits filed before exhaustion of administrative remedies are inappropriate and premature. *See, e.g., McGowan* 538 F. App'x at 498-99; *Coop. Benefit Adm'rs*, 367 F.3d at 336.

B. Plaintiff Failed to Exhaust His Administrative Remedies.

On February 5, 2016, HCC Life issued its initial written coverage decision to Plaintiff and explained the procedure for appealing its decision. (App. 1 (Ex. 1 – Decl. of Cooney) App.

2 at ¶ 7; also see Exhibit B to Decl. of Cooney, App. 41, at App. 42-47)[4] Plaintiff timely requested an appeal. (App. 1 (Ex. 1 – Decl. of Cooney) App. 4 at ¶ 12; also see Exhibit G, App. 61, at App. 62) But, on August 3, 2016, six days after requesting an appeal, and without submitting any further information, records, opinions, or analysis to the Insurer, Plaintiff filed this lawsuit. (*See* Pl.'s Original Petition, at Dkt. # 1-2)

By filing and serving this lawsuit before receiving a decision on appeal and not pursuing his appeal, Plaintiff violated the exhaustion tenets of ERISA; consequently, his claim is barred. *See, e.g. Bourgeois*, 215 F.3d at 479; *see also Coop. Benefit Adm'rs*, 367 F.3d at 336. Accordingly, Defendants are entitled to dismissal with prejudice of Plaintiff's lawsuit, or in the alternative, an award of summary judgment.

VI. ALL DEFENDANTS OTHER THAN THE INSURER OF THE WHOLLY INSURED PLAN SHOULD BE DISMISSED.

"[T]he proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan." *LifeCare Mgmt. Servs. LLC v. Ins. Mgmt. Adm'rs Inc.*, 703 F.3d 835, 844 (5th Cir. 2013) (quotation omitted); *see also Blum v. Spectrum Rest. Grp., Inc.*, 261 F. Supp. 2d 697, 708-09 (E.D. Tex. 2003) (plan sponsor was not proper party for ERISA benefit action); *Todd v. AIG Life Ins. Co.*, 47 F.3d 1448, 1458 (5th Cir. 1995) (an agent was not liable for plan benefits even where the agent made an erroneous decision in denying benefits).

Here, the Insurer HCC Life was delegated administrative authority, and it has the sole responsibility to adjust Plaintiff's claim and sole liability for benefits under the Plan. (App. 1 (Ex. 1 – Decl. of Cooney) App. 2 at ¶¶ 5-6; Exhibit A, App. 7-40 (The Policy); also see App. 67 (Ex. 2 – Decl. of Harnett) App. 69 at ¶ 11; also see Exhibit C, App. 380-381) Therefore, HCC

4 The pertinent passage of the written coverage decision is quoted in Paragraph 15, Statement of Facts, *supra*.

Life—and only HCC Life—would be the proper defendant if Plaintiff had filed a proper and timely claim for benefits under ERISA.

None of the other named defendants are responsible for payment of disability benefits under the Policy, and they not proper defendants as to an ERISA claim for benefits. *See Armando v. AT&T Mobility*, 487 F. App'x 877, 878-89 (5th Cir. 2012) (employer with ability to influence but not control benefit determinations was not a proper defendant for denial of benefits claim); *Picou v. Fed. Express Corp.*, 7 F. Supp. 3d 655, 658 (N.D. Tex. 2014) ("civil action for benefits due under an ERISA plan must be brought against the plan, rather than the plan sponsor"); *Kinnison v. Humana Health Plan of Tex., Inc.*, No. No. C-07-381, 2008 U.S. Dist. LEXIS 47351, at *39-46 (S.D. Tex. June 17, 2008) (dismissing § 502(a)(1)(B) claim where defendant is not the plan or the plan administrator and did not have the authority to make final decisions regarding plaintiff's eligibility for benefits); *Carroll v. United of Omaha Life Ins. Co.*, 378 F. Supp. 2d 741, 747 (E.D. La. 2005) (employer not a proper defendant to suit for benefits, where plan administrator, not employer, had ultimate authority to determine eligibility for benefits and the obligation to pay additional benefits if owed).

For this additional and independent reason, Defendants respectfully request that all defendants other than HCC Life be dismissed with prejudice.

VII. THE COURT DOES NOT HAVE PERSONAL JURISDICTION OVER DEFENDANT DANIEL LIBBY.

In addition to the reasons for dismissal set forth above, Defendant Daniel Libby is also entitled to dismissal because the Court lacks personal jurisdiction over him and he has not been properly served with process.

A. Libby's Motion to Dismiss for Insufficient Service of Process.

"A federal court is without personal jurisdiction over a defendant unless the defendant has been served with process in accordance with Rule 4 of the Federal Rules of Civil Procedure." *Bunch v. Mollabashy*, No. 3:13-CV-1075-G, 2015 U.S. Dist. LEXIS 38717, at *9 (N.D. Tex. March 26, 2015). Under Rule 4, service may be made by (1) delivering a copy of the summons and of the complaint to the individual personally, (2) leaving a copy of each at the individual's dwelling or usual place of abode with someone of suitable age and discretion who resides there, or (3) delivering a copy of each to an agent authorized by appointment or by law to receive service of process. Fed. R. Civ. P. 4(e). Alternatively, service may be made following state law for serving a summons in an action brought in courts of general jurisdiction in the state where the district court is located or where service is made. *Id.*

Here, Plaintiff purported to serve Libby by leaving a copy with another person at his place of business. (App, 382 (Ex. 3 – Decl. of Libby) at ¶ 3; also see App. 384-385 (Ex. 4 – Return of Service); see also Plaintiff's State Court Petition, Dkt. 1-2 at pg. 2; also see Dkt. 1-10) This was not proper service under Rule 4(e)(2). As a result, service could only be proper under Rule 4(e)(1) if it was proper service under Texas law (where this Court is located) or Massachusetts law (where service was attempted).

Under Texas law, absent the court granting a motion proving other attempts at service were futile (which did not happen here), service may only be made by personal delivery to the person or by mailing it to the person by certified mail, return receipt requested. Tex. R. Civ. P. 106. Similarly, under Massachusetts law, service must be made by delivering a copy of the summons and of the complaint to him personally; or by leaving copies thereof at his last and usual place of abode; or by delivering a copy of the summons and of the complaint to an agent authorized by appointment or by statute to receive service of process. *See* Mass. R. Civ. P.

4(d)(1). Although the process server's return claims the summons was left with the agent in charge at Libby's place of business (App, 382 (Ex. 3 – Decl. of Libby) at ¶ 3; also see App. 384-385 (Ex. 4 – Return of Service); also see Plaintiff's State Court Petition, Dkt. 1-2 at pg. 2; also see Dkt. 1-10), even if that was the agent in charge for the company, Plaintiff has not shown she was authorized to accept service for Libby ***individually*.**

Accordingly, because simply leaving the summons at Libby's place of business is not proper service under federal law, Texas law, or Massachusetts law, Plaintiff's claims against Libby should be dismissed under Rule 12(b)(5) for insufficient service of process.

B. Libby's Motion to Dismiss for Lack of Personal Jurisdiction.

As set forth above, ERISA requires dismissal of Plaintiff's claims in their entirety. *See* Sections II, III, and IV, *supra.* But even under Plaintiff's artful (albeit incorrect) pleading of only alleged state law claims, Plaintiff cannot establish this Court has personal jurisdiction over Libby. Under Plaintiff's theory of the case, this Court only has personal jurisdiction over Libby only if (1) the state's long-arm statute confers personal jurisdiction; and (2) the exercise of jurisdiction is consistent with due process. *See Mullins v. TestAmerica, Inc.*, 564 F.3d 386, 398 (5th Cir. 2009). To satisfy due process requirements, Plaintiff must show that (1) the nonresident defendant established minimum contacts by "purposely avail[ing] himself of the benefits and protections of the forum state'" and (2) "the exercise of jurisdiction does not offend traditional notions of fair play and substantial justice." *Id.* (quotations omitted).

1. Plaintiff Failed to Plead any Facts Showing Personal Jurisdiction over Libby.

Although unclear due to Plaintiff's group-pleading, it appears Plaintiff contends this Court has personal jurisdiction over Libby because "Defendants committed torts in whole or in part in this state, have a general presence in this state, have a principal office in this state, have

violated Texas insurance laws in this state, and have purposefully availed themselves of the benefits of this great state (actually the greatest state in the Union), and/or have consented to jurisdiction here." (Pl.'s Original Petition, Section III.A., at Dkt. # 1-2) Plaintiff, however, failed to allege even a single act by Libby showing that he has purposefully availed himself of a Texas forum. Accordingly, Plaintiff's claims against Libby should be dismissed for lack of personal jurisdiction based on Plaintiff's insufficient pleading of any alleged jurisdictional facts. *See Panda Brandywine Corp. v. Potomac Elec. Power Co.*, 253 F.3d 865, 868-70 (5th Cir. 2001) (affirming dismissal for lack of personal jurisdiction because plaintiff's only evidence was a conclusory jurisdictional allegation)

2. Plaintiff Cannot Establish Personal Jurisdiction over Libby.

Even ignoring Plaintiff's defective pleading, this Court still lacks personal jurisdiction over Libby. It is well-settled that personal jurisdiction can be established through either general jurisdiction or specific jurisdiction. For an individual, such as Libby, general jurisdiction is found where the person is domiciled. *See Pervasive Software, Inc. v. Lexware GmbH & Co.*, 688 F.3d 214, 221 (5th Cir. 2012). Here, Libby lives in and is domiciled in Massachusetts. (App. 382-83 (Ex. 3 – Decl. of Libby) at ¶¶ 3-4) This Court therefore lacks general jurisdiction over Libby.

Similarly lacking is any actions or connections to Texas that would support a claim of specific jurisdiction over Libby. "For a State to exercise jurisdiction consistent with due process, the defendant's suit-related conduct must create a substantial connection with the forum State." *See Walden v. Fiore*, 134 S. Ct. 1115, 1121 (2014) Here, Libby has virtually zero connection to Texas. Libby owns no land in Texas, nor does he have any ties to Texas. (App. 383 (Ex. 3 – Decl. of Libby) at ¶ 5) It is irrelevant that Plaintiff previously played hockey in Dallas or that he decided to hire Dallas lawyers. *See Walden*, 134 S. Ct. at 1122 (for specific jurisdiction "the

relationship must arise out of contacts that the 'defendant *himself*' creates with the forum State") (emphasis in original). Thus, Plaintiff failed to plead any jurisdictional facts regarding Libby for a simple reason—there are none.

Accordingly, the Court should grant Libby's Motion and dismiss Plaintiff's claims against him for lack of personal jurisdiction under Rule 12(b)(2).

CONCLUSION

In sum, the NHL and the NHLPA provided disability coverage to all eligible NHL players, including Plaintiff, under an employee welfare benefit plan that is subject to ERISA. As set forth above, the ERISA Plan at issue exists, it does not fall within the DOL's Safe Harbor Regulations, and it was "established and maintained" by the NHL (on behalf of the NHL Clubs) and the NHLPA. Plaintiff's claims, therefore, are preempted by ERISA. In addition, because Plaintiff failed to exhaust administrative remedies as required by ERISA before filing and serving this lawsuit, he is not entitled to pursue judicial remedies. For these reasons, this Court should dismiss Plaintiff's Complaint with prejudice or enter summary judgment against Plaintiff on all claims.

In the alternative, the Court should enter partial summary judgment finding that this matter is governed by ERISA and dismiss all defendants except HCC Life. The Court should also dismiss all claims against improperly served Daniel Libby pursuant to Rule 12(b)(2) and Rule 12(b)(5).

Respectfully submitted,

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ATTORNEYS FOR DEFENDANTS

CERTIFICATE OF SERVICE

On September 23, 2016, I electronically filed the foregoing document with the Clerk of Court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the Court. Service on all attorneys of record who are Filing Users will be automatically accomplished through notice of electronic filing.

/s/ Mike Birrer